		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045245

Facility Name: Prairie Rose Health Care Center

Address: 900 South Chestnut Street (Number) Pana (City) 62557 (Zip Code)

County: Christian

Telephone Number: 217-562-3996 **Fax #** 217-562-4005

IDPA ID Number: 51-0271905

Date of Initial License for Current Owners: 0

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Karl Baker, BKD, LLP **Telephone Number:** 314-231-5544

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Chad Butterfield, THCSLLC, Mgt. Co. for
(Title) Prairie Rose Health Care Center

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax #

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	121	Skilled (SNF)	121	44,165	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	0	Intermediate (ICF)	0	0	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	121	TOTALS	121	44,165	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,842	17	2,542	6,401	8
9	SNF/PED	0	0	0		9
10	ICF	20,529	4,010	521	25,060	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	24,371	4,027	3,063	31,461	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.24%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Y

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/1/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 25 and days of care provided 2,471

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	149,581	11,634	8,745	169,960		169,960	(3,693)	166,267			1
2	Food Purchase		129,190		129,190		129,190		129,190			2
3	Housekeeping	88,995	19,188		108,183		108,183		108,183			3
4	Laundry	39,537	11,497	53	51,087		51,087		51,087			4
5	Heat and Other Utilities			95,508	95,508		95,508		95,508			5
6	Maintenance	24,854	5,675	24,561	55,090		55,090		55,090			6
7	Other (specify):*			2,347	2,347		2,347		2,347			7
8	**TOTAL General Services**	302,967	177,184	131,214	611,365		611,365	(3,693)	607,672			8
	B. Health Care and Programs											
9	Medical Director			28,042	28,042		28,042		28,042			9
10	Nursing and Medical Records	1,258,179	103,063	3,884	1,365,126		1,365,126		1,365,126			10
10a	Therapy		581	121,774	122,355		122,355		122,355			10a
11	Activities	30,925	1,910	2,785	35,620		35,620		35,620			11
12	Social Services	63,388	193	2,785	66,366		66,366		66,366			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,352,492	105,747	159,270	1,617,509		1,617,509		1,617,509			16
	C. General Administration											
17	Administrative	70,048	(1,391)		68,657		68,657		68,657			17
18	Directors Fees											18
19	Professional Services			273,514	273,514		273,514	4,016	277,530			19
20	Dues, Fees, Subscriptions & Promotions			46,073	46,073		46,073	(24,062)	22,011			20
21	Clerical & General Office Expenses	59,713	23,820	70,172	153,705		153,705	(52,360)	101,345			21
22	Employee Benefits & Payroll Taxes			221,490	221,490		221,490	8,046	229,536			22
23	Inservice Training & Education			212	212		212		212			23
24	Travel and Seminar			5,383	5,383		5,383	1,220	6,603			24
25	Other Admin. Staff Transportation			6,467	6,467		6,467	(2,263)	4,204			25
26	Insurance-Prop.Liab.Malpractice			99,730	99,730		99,730	1,712	101,442			26
27	Other (specify):*											27
28	**TOTAL General Administration**	129,761	22,429	723,041	875,231		875,231	(63,691)	811,540			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,785,220	305,360	1,013,525	3,104,105		3,104,105	(67,384)	3,036,721			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Prairie Rose Health Care Center #0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			188,449	188,449		188,449	(1,145)	187,304			30
31	Amortization of Pre-Op. & Org.			147,813	147,813		147,813	(147,813)				31
32	Interest			506,635	506,635		506,635	(5,283)	501,352			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,137	1,137		1,137		1,137			35
36	Other (specify):*											36
37	**TOTAL Ownership**			844,034	844,034		844,034	(154,241)	689,793			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		344,641	121,128	465,769		465,769		465,769			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,148	67,148		67,148		67,148			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		344,641	188,276	532,917		532,917		532,917			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,785,220	650,001	2,045,835	4,481,056		4,481,056	(221,625)	4,259,431			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,977)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		39		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,283)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		32		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		2		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,263)	25		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,018)	21		24
25	Fund Raising, Advertising and Promotional	(24,062)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,535)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (51,138)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(147,813)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(22,674)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (170,487)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (221,625)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Prairie Rose Health Care Center

ID# 0045245

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vendor Income	$ (716)	1	1
2	Barber and Beauty Revenue	0	40	2
3	Extraordinary Income/(Expense)			3
4	(Gain)/Loss on Sale of Assets	(6,843)	30	4
5	Miscellaneous (Income)/Expense	(2,674)	21	5
6	Adjust Depreciation Expense to Schedule XI	5,698	30	6
7	Raw foods rebate	0	2	7
8	Adjust R/E taxes to actual	0	33	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,535)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Rose Health Care Center **#** 0045245 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(3,693)	0	0	0	0	0	0	0	0	0	0	(3,693)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,693)	0	0	0	0	0	0	0	0	0	0	(3,693)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,016	0	0	0	0	0	0	0	0	0	4,016	19
20	Fees, Subscriptions & Promotions	(24,062)	0	0	0	0	0	0	0	0	0	0	(24,062)	20
21	Clerical & General Office Expenses	(14,692)	(37,668)	0	0	0	0	0	0	0	0	0	(52,360)	21
22	Employee Benefits & Payroll Taxes	0	8,046	0	0	0	0	0	0	0	0	0	8,046	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,220	0	0	0	0	0	0	0	0	0	1,220	24
25	Other Admin. Staff Transportation	(2,263)	0	0	0	0	0	0	0	0	0	0	(2,263)	25
26	Insurance-Prop.Liab.Malpractice	0	1,712	0	0	0	0	0	0	0	0	0	1,712	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(41,017)	(22,674)	0	0	0	0	0	0	0	0	0	(63,691)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(44,710)	(22,674)	0	0	0	0	0	0	0	0	0	(67,384)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(1,145)	0	0	0	0	0	0	0	0	0	0	(1,145)	30
31	Amortization of Pre-Op. & Org.	(147,813)	0	0	0	0	0	0	0	0	0	0	(147,813)	31
32	Interest	(5,283)	0	0	0	0	0	0	0	0	0	0	(5,283)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(154,241)	0	0	0	0	0	0	0	0	0	0	(154,241)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(198,951)	(22,674)	0	0	0	0	0	0	0	0	0	(221,625)	45

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Midwest Care Centers, Inc.		Prairie Rose Health Care Center	Pana, IL			
Midwest Care Centers, Inc.		Medicos Health Care Center	Detroit, MI			
Midwest Care Centers, Inc.		Fair Oaks Health Care Center	South Beloit, IL			
Midwest Care Centers, Inc.		El Paso Health Care Center	El Paso, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Services	$	Midwest Care Centers, Inc.	100.00%	$ 4,016	$ 4,016	1
2	V	21	Clerical & Other Gen Office	37,892	Midwest Care Centers, Inc.	100.00%	224	(37,668)	2
3	V	22	Employee Bfts & Payroll Taxes		Midwest Care Centers, Inc.	100.00%	8,046	8,046	3
4	V	24	Travel and Seminar		Midwest Care Centers, Inc.	100.00%	1,220	1,220	4
5	V	26	Insurance		Midwest Care Centers, Inc.	100.00%	1,712	1,712	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 37,892			$ 15,218	$ * (22,674)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Midwest Care Centers, Inc.
Street Address: 7611 State Line Road, Suite 301
City / State / Zip Code: Kansas City, Missouri 64114
Phone Number: (816) 444-0900
Fax Number: (816) 822-8799

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Patient Days	133,256	4	$ 17,011	$	31,461	$ 4,016	1
2	21	Clerical & Other Gen Office	Patient Days	133,256	4	947		31,461	224	2
3	22	Employee Bfts & Payroll Taxes	Patient Days	133,256	4	34,079		31,461	8,046	3
4	24	Travel and Seminar	Patient Days	133,256	4	5,166		31,461	1,220	4
5	26	Insurance	Patient Days	133,256	4	7,250		31,461	1,712	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 64,453	$		$ 15,218	25

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	City of Pana		X	Mortgage	Varies	3/1/95	$ 3,250,000	$ 3,575,567	1/1/25	9.50%	$ 231,254	1
2	Notes Payable		X		Varies			95,235				2
3	Capital Lease Obligations		X	Capital Lease				1,538				3
4	Debt Restructuring										233,865	4
5												5
	Working Capital											
6	Interest Income		X								(5,283)	6
7	H/O Interest Income	X										7
8	Parent Co. LOC	X		Line of Credit				169,677			41,516	8
9	TOTAL Facility Related						$ 3,250,000	$ 3,842,017			$ 501,352	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,250,000	$ 3,842,017			$ 501,352	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Rose Health Care Center COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0045245

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick and block Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 238,764 2. Number of Years Over Which it is Being Amortized: Various

3. Current Period Amortization: 147,813 4. Dates Incurred: Various

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home			$ 13,500	1
2					2
3	TOTALS			$ 13,500	3

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	121		95	76	$ 1,068,665	$ 35,622	30	$ 35,622	$ (0)	$ 243,418	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1986 Additions			86	970,363	32,345	30	32,345	0	487,877	9
10	1987 Additions			87	110,922	3,680	29	3,825	144	56,022	10
11	1989 Additions			89	2,219		10			2,219	11
12	1990 Additions			90	4,295	42	30	143	101	3,529	12
13	1991 Additions			91	134,283		7			134,283	13
14	1992 Additions			92	17,130		7			17,130	14
15	1993 Additions			93	24,239		7			24,239	15
16	1994 Additions			94	10,559	465	7	465	(0)	10,559	16
17	1995 Additions			95	14,617	1,031	15	974	(56)	6,728	17
18	1996 Additions			96	305,057	23,376	12	25,421	2,046	(210,658)	18
19	1997 Additions			97	23,542	2,354	10	2,354	0	9,702	19
20	Whirlpool bath			98	9,120	912	10	912		3,648	20
21	Lift, bath trolley			98	3,850	385	10	385	0	1,540	21
22	Shower room			98	4,884	488	10	488		1,913	22
23	Entrance doors			98	2,358	118	20	118		383	23
24	curtains			98	6,102	1,220	5	1,220	(0)	3,865	24
25	Sidewalk & pad			99	1,484	99	15	99	0	256	25
26	Divide receipts on emergency generator			99	2,397	120	20	120	(0)	300	26
27	Med room cabinets, counter top			99	2,008	100	20	100	(0)	201	27
28	Heat/cool			2000	1,876	268	7	268	(0)	357	28
29	Door alarms			2001	1,215	54	15	54	(0)	54	29
30	Building - renovation project			2001	94,315	1,810	30	1,810	0	1,810	30
31	Wooded doors			2001	1,900	11	15	11	0	11	31
32	Landscaping - renovation project			2001	1,174	68	10	68	(0)	68	32
33	Bituminous Parking lot			2001	22,030	229	8	229		229	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,840,603	$ 104,800		$ 107,034	$ 2,234	$ 799,681	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 600,181	$ 75,473	$ 75,473	$		$ 512,270	71
72	Current Year Purchases	38,386	1,475	1,475			1,475	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 638,567	$ 76,948	$ 76,948	$		$ 513,745	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Van	1994	$ 27,905	$ 3,322	$ 3,322	$	7	$ 27,905	76
77										77
78										78
79										79
80	TOTALS			$ 27,905	$ 3,322	$ 3,322	$		$ 27,905	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	3,520,575	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	185,070	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	187,304	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	2,234	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,341,331	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	WIP	$ 3,681	92
93			93
94			94
95		$ 3,681	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 1,137 Description: See attached detail
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$	279	$ 30,446	$	279	$ 30,446	1
2	Licensed Speech and Language Development Therapist		hrs		35	21,921		35	21,921	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		546	69,387		546	69,387	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	860	$ 121,754	$	860	$ 121,754	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 18,238	$	1
2	Cash-Patient Deposits	2,106		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	593,851		3
4	Supply Inventory (priced at)	24,575		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	31,397		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 670,167	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	36,704		13
14	Buildings, at Historical Cost	2,755,992		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	790,305		16
17	Accumulated Depreciation (book methods)	(1,358,487)		17
18	Deferred Charges	434,467		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	531,123		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,190,104	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,860,271	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 336,940	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	321,879		29
30	Accrued Salaries Payable	117,025		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other liab.'s and Patient Trust Dep	23,658		36
37	Due to affiliates	434,467		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,233,969	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,577,105		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,577,105	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,811,074	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (950,803)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,860,271	$	48

***(See instructions.)**

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (284,182)	1
2	Restatements (describe):		2
3	**Prior period adjustment**	502,545	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 218,363	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(669,166)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(500,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,169,166)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (950,803)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,277,612	1
2	Discounts and Allowances for all Levels	(1,581,580)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,696,032	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	817,949	6
7	Oxygen	244,538	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,062,487	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	716	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,977	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,693	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,283	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,283	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Extraordinary Income/Loss & Miscellaneous**	37,552	28
28a	**Gain/Loss on Sale of Asset**	6,843	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 44,395	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,811,890	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	611,365	31
32	Health Care	1,617,509	32
33	General Administration	875,231	33
	B. Capital Expense		
34	Ownership	844,034	34
	C. Ancillary Expense		
35	Special Cost Centers	465,769	35
36	Provider Participation Fee	67,148	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,481,056	40
41	**Income before Income Taxes (line 30 minus line 40)****	(669,166)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (669,166)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	7,972	7,972	$ 161,545	$ 20.26	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	10,118	16,648	168,596	10.13	3
4	Licensed Practical Nurses	24,475	30,983	321,457	10.38	4
5	Nurse Aides & Orderlies	69,518	56,480	588,240	10.42	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0			8
9	Activity Director	4,320	4,320	30,925	7.16	9
10	Activity Assistants	0	0	0		10
11	Social Service Workers	6,206	6,206	63,388	10.21	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	21,370	21,370	149,581	7.00	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	2,274	2,274	24,854	10.93	17
18	Housekeepers	12,973	12,973	88,995	6.86	18
19	Laundry	6,486	6,486	39,537	6.10	19
20	Administrator	3,337	3,337	70,048	20.99	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	6,100	9,437	59,713	6.33	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	2,766	2,766	18,342	6.63	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,915	181,252	$ 1,785,220 *	$ 9.85	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	213	$ 8,745	line 1, col 3	35
36	Medical Director	216	28,042	line 9, col 3	36
37	Medical Records Consultant			line 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	448	3,584	line 10, col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	52	2,785	line 11, col 3	44
45	Social Service Consultant	46	2,785	line 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	975	$ 45,941		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	Ln 10, Col 1	50
51	Licensed Practical Nurses		0	Ln 10, Col 1	51
52	Nurse Aides		0	Ln 10, Col 1	52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Johnson	Administrator		$ 70,048
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 70,048

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various	Purch Serv	$ 1,916
Tutera Health Care Mgt	Management Fees	227,350
Various	Legal Fees	18,644
Various	Accounting Fees	10,618
Various	D/P Fees	9,610
Various	Professional Serv	4,376
Various	Trustee Expenses	1,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 273,514

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,384
Unemployment Compensation Insurance	32,386
FICA Taxes	110,684
Employee Health Insurance	12,409
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	627
Home office allocation	8,046
TOTAL (agree to Schedule V, line 22, col.8)	$ 229,536

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 613
Advertising: Employee Recruitment	10,445
Health Care Worker Background Check	4,163
(Indicate # of checks performed 106)	
Dues and Subscriptions	6,790
Advertising PR & Other	24,062
Home Office Allocation	0
Less: Public Relations Expense	( )
Non-allowable advertising	(24,062)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,011

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,383
Home office allocation	1,220
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,603

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
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14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? N

(2) Are there any dues to nursing home associations included on the cost report? Y
If YES, give association name and amount. IHCA, 6435.18

(3) Did the nursing home make political contributions or payments to a politica action organization? N If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Y If YES, what is the capacity? 118

(5) Have you properly capitalized all major repairs and equipment purchases? Y
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 11,714 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Y If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? N
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES N NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO N If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 67,148
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? N If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Y

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? Y Indicate the amount. $ 2,977

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? N
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? N If YES, please indicate the amount of income earned from such a program during this reporting period. $ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Y
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Y
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Y
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? N
Firm Name: BKD The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N If no, please explain. In progress

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Y

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Y
Attach invoices and a summary of services for all architect and appraisal fees.